CHAPTER 5 : CONCLUSION, IMPLICATIONS AND SUGGESTIONS FOR FURTHER RESEARCH.

5.1. Conclusion.

The Move structure analysis therefore creates a possibility of how the reports may be sucessfully written. Any attempt to standardise writing may give an impression of prescriptism, that is to say that reports should be written in a certain way, but in reality it may be thought of as a tool for reflection and understanding a set of surface rules which can be applied. Rules for structure and for style are in the end impossible because the surface form of the text is to some extent shaped by the context it carries. However it can assist in training doctors on how to write effectively in that it provides a model which writers of medical reports may use. A satisfactory model and description of medical reports will in the end enhance the ability of non native speaker students to understand and eventually produce these reports.

The Move structure proposed can be thought of as a model because it tells us what medical reports are really like. Therefore it makes sense to use the moves posited in medical reports as a means of ensuring that information is conveyed correctly and appropriately. The model offers patterns which can be clearly understood by the inexperienced writers of this type of reports. It can be used as a guide to familiarise the newcomer with the conventions found in this particular genre. The experienced writers

may already be aware of when and how these patterns are used and how they may be altered to suit the writer's purposes. The Move structure analysis applicable to medical reports will help the novice writer in the organisation and content of the report.

5.2. Implications of the study.

This study has examined medical reports which are routinely written in the day to day operation of the hospital. Patients seek treatment and eventually get better. Some may develop complications and some may even die. In the course of treatment, hospitalisation, surgery or death, requests are made for medical reports. These requests are made by the patient and his/her family to understand better what was done to them in hospital, and in some cases to claim compensation from insurance companies or the SOCSO board; to inform employers of temporary or permanent disabilities so that lighter duties be given; and to be used in court cases especially in accident and industrial accident cases.

The benefit of these reports to the patient is that the patient understands what happened to him in hospital and this document allows him to make insurance claims from insurance companies of which he is a policy holder. The patient is also able to make medicolegal claims in courts against the party responsible for the accident or injury and seek compensation. In cases of semi or permanent disability,these reports also allow the patient to make

claims from the SOCSO board. Benefits to the writers of the reports and the administration would be to report events as they happened, but the risk is that these reports may also show shortcomings or improper management of the patient.

In this dissertation my purpose has been to examine these reports comprehensively to reveal the patterns of structure based on regularities that are evident. This overall pattern has enabled me to devise a Move structure that is representative of medical reports. Since the construction of the overall text is shaped in response to the context of the situation which gives rise to it, the communicative purpose of reporting is also examined.

Although these reports are routinely written, care has to be taken that the information required in the reports is accurate and adequate. It should inform the reader of what actually happened in concise and appropriate language. However when information is transferred from numerous records and condensed into a brief report, loss of information may occur. This loss of information may have medicolegal consequences since the absence of significant information may indicate that nothing was done. The information gaps may be attributable to the doctor's lack of precise knowledge about what information to include in the report and what to leave out. Malpractice cases can come to trial anywhere from two to ten years after an event. As a result the medical report and records are the only documentation available to prove what happened and is in fact the most

important evidence in a malpractice trial. Juries are more likely to believe documented evidence than witnesses who rely on memory of an event that happened several years ago. It stands to reason then, that a report that is accurate and well documented helps the case.

Precise knowledge of what to include is important because it is for the writer's interest that the report be completed in the most accurate way possible. The writer is solely responsible if the case is subpoenaed in court although he may have never seen the patient but had written the report based on the records in the patient's file. The medical report is an extremely important piece of documentation not only for medical purposes but also for the doctor's legal defence. The doctor as the writer of the report is solely responsible for the production of the report and the importance of accurate reporting for the legal defence of the writer is crucial.

The Move Structure analysis and the four Moves suggested for medical reports offer practical suggestions as to how doctors should write these reports. Therefore this study not only contributes to an understanding of the organisation of medical reports but also demonstrates how an overall Moves analysis can give insights into the shape of such texts.

5.3. Limitations of study.

The limitation of this study is that the data sample is small, but this small homogeneous sample known as medical reports was able to reveal the pattern of organisation and the language used to express these patterns. It is able to show the presence of overall behavioral patterns negotiated by the writers of the reports and the language found in them. The writers undertook a task and a responsibility and behavioral demands were made upon them. Language is used here to structure and make sense of some aspects of experience.

The writers employed different ways of using language to shape their experience and to create particular kinds of information. Since language is never used at random and never unstructured, an overall pattern was evident from the sample studied. The role of the writer here is to inform accurately and adequately in brief and concise language, and this study attempts to reveal the patterns negotiated by the writers from the samples/data studied and to generalise this pattern into a model for novice writers.

5.4. Suggestions for further research.

This research is concerned with examining only one type of report, the medical report. Further research could examine other types of reports written by doctors such as post mortem reports and examine its

communicative function, organisation and language. Research into the communicative purposes for all types of reports written by doctors could be carried out to examine if all these reports have the same communicative purpose. All these reports could be studied in depth and contrasts between these reports can be a useful baseline for new doctors to create quality reports. Given the increasing role of reports in health care, more studies on the organisation of information and language use in report writing should be carried out.

APPENDIX A

Medical Report On			
Identity Card No.		Registration No	
Age		Sex	
Date admission		Date Discharge	

Presented to Eye clinic on 10/6/94 with painful right eye 2 days duration.
No history of trauma or medical illness.
Noted poor vision right eye 1 year duration.

Eye examination on 10/6/96 revealed:

- Best corrected vision Light perception right and 6/6 left.
- Intra ocular pressure 12 mm. Hg both eyes.
- Right eye RAPD++, Immature cataract.
- Right eye moderate anterior uveitis with seclusio pupil that resists dilation thereby.
- Left eye was normal in all aspects.

Investigation:

- Ultrasound B scan Right eye on 30/6/94 - no retinal detachment.
- Collagen screening tests, Mantoux test, VDRL, X-ray chest and pelvis were all normal.
- Serum Toxoplasma on 6/7/94 was 1:64 IgG titres raised significantly to suggest immunological experience to toxoplasmasis.

Treatment and progress:

Patient was referred to medical clinic on 28/2/95 for abnormal blood sugar levels for further management.

Right cataract surgery was proposed but patient deferred the surgery after being told of the poor and guarded visual outcome in his right eye because of the previous anterior uveitis.

The right vision had no perception to light on 5/3/96 and there was no anterior chamber activity noted.

On 22/4/97 - the best corrected vision was NPL right and 6/9; the intra ocular pressure was 4mmHg right and 12mmHg left.

The left eye was normal in all aspects.

He has good monocular vision left eye.

Patient was advised follow-up review on 1/12/97

Medical Report On			
Identity Card No.		Registration No	
Age		Sex	
Date admission		Date Discharge	

Admitted unconscious.
No history available.

On examination:

Unconscious
Responding to deep pain
Neck stiffness (+)
No haematoma scalp
Pupils - Unequal, sluggish reaction
Blood Pressure - 137/9o. Pulse Rate - 123/Min
T -37.50C
Flushed
Bilat conjunctival chemosis (+)
(Right) Periorbital haematoma and vitrenous Haemorrhage and commotio Retinae
Heart - DRNM
Lungs - Transmitted sounds (+)
Per Abdomen - soft
Cardiovascular system - stiffness both upper limbs.
Otherwise normal
FBC - Hb - 17.1/TW - 9.7/Plat - 41,000
PCV - 55.1%
Buse - urea 8.6/Na 142/Kt - 2.5/Cl - 98
RBS - 9.3
CT Scan Brain - Subdural haematoma with fracture (Right) temporal bone
Chest X-ray - Haziness (Right) upper lobe

Management

ECG - sinus tachycardia
Patient given iv fluids 6.0 over 24(H)
IV Cpen/Chloromycetin started
Kept Nil orally
IV Zantac 50mg tds
NG Tube inserted
4 units platlet concentrate) transfused
2 units FFP) transfused
Vitamin K 10mg daily given

Patient suddenly arrested in ward

Cardiopulmonary, resuscitation started but unsuccessful
Relatives refused post-mortem
Cause of death: Subdural haematoma secondary to fracture right temporal bone

Medical Report On			
Identity Card No.		Registration No	
Age		Sex	
Date admission		Date Discharge	

History

Alleged involved in Industrial Accident on 29.10.96 sustained crush injury of (left) hand while working

Injuries:

2. Compound fracture proximal phalanx with near amputation of the (left) thumb
3. Amputation of (left) index finger at level of proximal phalanx
4. Compound fracture phalanges of (left) middle finger
5. Fracture metacarpal of (left) middle finger

X-ray - Corresponds to above injuries

Management:

Analgesic/antibiotics given
Wound debridement with k-wiring done for (left) thumb and middle finger
Refashioning amputated stump of (left) index finger done
He was treated for Diabetes mellitus with oral hypoglycaemic agents
Apparently, on follow-up he was noted to have pus discharge from (left) thumb wound
I + D done 24/12/96
Advise on daily wound dressing

Follow-up

Given regular follow-up
Wound was healing well. K-wire was removed on 18.12.96
Advise on occupational therapy and daily wound dressing with further follow-up

Medical Report On			
Identity Card No.		Registration No	
Age		Sex	
Date admission		Date Discharge	

The above patient, 2½ years old Indian boy was admitted to ward 6B with history of puffiness of the face for one month duration and fever with cough for one day duration prior to admission. Patient was previously well.

The puffiness of the face occurs every morning and resolves by the evening. Went to see General Practitioner three times but the symptom persist. No history suggestive of urinary tract infection. Urine test at General Practitioner shows urine protein ++++, red blood cell moderate. One day prior to admission started having fever of high grade associated with cough.
Other history - Nil of significance.

On examination:

General condition : fair
Face : mild puffiness
Weight : 13 kg
Blood Pressure : 132/35 mmHg
Heart Rate : 160/min
Respiratory Rate : 20/min
Temperature : 38.3°C
Fundus : Normal
Throat : Mildly inflamed
Tonsil : Not enlarged
Cardiovascular system) No abnormality detected
Respiratory system) "
Abdomen - mild ascites, Liver 3 cm
No scrotal/pedal edema
In the ward - urine cloudy.
Since admission Blood Pressure stable

Investigation Results:

1. Blood - FBC - Normal
   Buse - Normal
   Se Uric Acid - 161 (Normal)
   Se Albumin - result pending
   Se cholesterol - result pending
2. Urine - 24 hours urine protein - result pending

Management:

Start induction regime - Sy. prednisolone - 15 mg oN
- 10 mg oN
Then continue with maintenance regime - Sy prednisolone 10 mg EOD x 4/52
Tor follow-up at paediatric clinic within one month after discharge from the ward.

Medical Report On			
Identity Card No.		Registration No	
Age		Sex	
Date admission		Date Discharge	

The above named was admitted to male medical ward here for chest pain for one day.
He is diabetic for 3 years on oral medications.
He was treated for unstable agina and blood test revealed he was also having hyperlipidaemia.
He recovered well and discharged after 4 days of admission with oral medications for his diabetes and ischaemic heart disease.

Subsequently he came for review at medical clinic regularly, his blood pressure and blood sugar is well controlled.
He is due for review on 29.7.97

Medical Report On			
Identity Card No.		Registration No	
Age		Sex	
Date admission		Date Discharge	

The above named patient had undergone an operation for a uterine fibroid at a private specialist medical centre on 29.12.96 and was noted to have developed a sudden onset of Right sided weakness and dysphasia on 30.12.96.

An urgent CT scan done revealed a ischemia infarction with cerebral oedema. She was referred to us for further management. Examination on arrival at this hospital revealed that she was comatosed (COMA IV), had hyperrflexia on the (right) sided with an up-going (right) plantar. However blood pressure was 170/100 with a pulse of 84/min.

Her condition deteriorated and at 9.00 am on 31.12.96 she suffered a cardio-respiratory arrest. Inspite of Active resuscitation, she did not respond and was pronounced dead at 9.15 am.

Cause of Death : Cerebro vascular Accident due to cerebral infarct with cerebral oedema.

Medical Report On			
Identity Card No.		Registration No	
Age		Sex	
Date admission		Date Discharge	

67 years Chinese man, known case of Hypertension on medication.
Presented with history of weakness over the (left) upper limb x 5/12.
Had history fall 2 years ago and sustained soft tissue injury over (left) shoulder and upper limb.

On examination:

He was noted to have weakness over left upper limb compared to (right) upper limb with decrease sensation over C6 - T1 dermatomes.

X-ray - shows narrowing intervertebral disc space of C5 - C6.
Sclerotic changes of C6 vertebre.

Management:

He was treated medically and referred to orthopaedic for further management.
He was given conservative management and advised on (left) upper limb physio.
Given regular follow-up
On follow-up his neurological status has improved.
He was discharged 26.3.97 with no further follow-up

Medical Report On			
Identity Card No.		Registration No	
Age		Sex	
Date admission		Date Discharge	

History:

A known case of Diabetes mellitus for 7 years on T. Daonil 10 mg om and 5 mg on night. Complained of weakness of the (left) side of body since January 1997 when seen in May 97 at medical clinic. The weakness of the (left) upper limbs and (left) lower limbs is slowly improving. He was treated in specialist medical centre for the above complains.
CT Scan done there showed right frontal lobe infarct. Initially be had slurred speech in January 97 but speech completely improved now.

On examination:

Patient's vital signs were within normal limits and systemic examinations were unremarkable except for central nervous systems where the power over the left upper limbs were decreased i.e. 4+/5, and the plantar reflex over the (left) side was up going.

Investigations:

Awaiting blood investigation

Treatment:

T Persentin 75 mg tds
Glucophage 500 mg tds
T Daonil 5 mg BD

Diagnosis: 1. Diabetes Mellitus
2. (right) Frontal Lobe Infact with (left) Hemiparesis

Progress: Has follow-up in MOPD in four months and advised on physiotherapy.

Medical Report On			
Identity Card No.		Registration No	
Age		Sex	
Date admission		Date Discharge	

Presented with poor vision right eye on 25.2.97 with history of trauma to right eye 2 years ago. No history of medical illness.

Eyes examination on 25.2.97 revealed:

- Best corrected visual acuity was Hand movement right and 6/6 left.
- Intraocular pressures both eyes were normal.
- Mild divergent squint right eye.
- Matured cataract right eye and no view of posterior segment.
- No RAPD right eye.
- Left eye normal in all aspects.

Investigations:

- Right eye posterior segment B-scan on 25.2.97 was normal.
- Hemotalogical investigations for young cataract were all normal.

He was diagnosed as Right Traumatic matured cataract. He underwent successful right cataract extraction with posterior chamber intra ocular lens implantation on 30.4.97 under general anaesthesia. When he was examined on 3.6.97, the best corrected visual acuity was 6/6 right and 6/6 left.

He defaulted follow-up examination on 17.6.97.

Medical Report On			
Identity Card No.		Registration No	
Age		Sex	
Date admission		Date Discharge	

Known Hypertension and Ischaemic heart disease.

Currently on: Tab. Metaprolol 200 mg bd
Tab. Isordil 10mg tds
Tab Aspirin 150 mg daily
S/L GTN PRN
Comfortable, Blood Pressure 150/90 Temperature 38°C Hess test - negative.
Lungs - clear, Cardiovascular system - normal.
Abdomen - soft, non-tender, no arganomegaly.
No lymphadenopathy.

Investigations:

ECG - No ischaemic or infarct changes.
FBC - HB - 14.10%, Platlet count - 1. 61,000
2. 141,000
Cardiac enzymes - normal
UFEME - normal. Chest X-ray - normal

Diagnosis - 1. Upper respiratory tract infection
2. Hypertension
3. Ischaemic heart disease

Treatment:

T Ceporex 500mg tds x 1 week.
T Isordil 10 mg tds.
T Metroprolol 200 mg BD.
T Aspirin 150 mg daily.
S/C GTN/PRN.
Under medical clinic follow-up

Medical Report On			
Identity Card No.		Registration No	
Age		Sex	
Date admission		Date Discharge	

The above named patient was admitted to the medical ward on 17.1.97 with a history of change in behaviour (from) about 2 am in the morning. She had a history of hypertension during her pregnancy and had delivered a child about 1 week prior to the onset of this illness.

On examination she was noted to be conscious and able to move all four limbs, did not obey command. Her vital signs were stable.
A Provisional diagnosis of Postpartum psychosis was made.

Later that evening, she was noted to have deteriorated and was restless with choreiform movement. It was noted that she (had) a foul smelling vaginal discharge. In view of the current clinical finding, the probable diagnosis of peuperal sepsis.

She had an urgent CT scan of the brain done on 18.1.97 and was reported as normal.
In view of her condition which was deteriorating, it was advised that a lumbar puncture be done.
However the relatives were not keen and no consent was given.

She had a cardio-pulmonary arrest at 8.35 pm on 18.1.97 and despite active resuscitation, she did not respond. She was pronounced dead at 10.00 pm

Cause of death: Pueperal Sepsis with meningitis.

Medical Report On			
Identity Card No.		Registration No	
Age		Sex	
Date admission		Date Discharge	

History:

Motorcyclist alleged involved in motor vehicle accident on 6.12.96.
On admission his Glassgow Coma Scale has deteriorated.
He was subjected to elective intubation and ventilated.
He sustained close fracture right femur with compound fracture of (right) tibia and fibula.
CT Scan of brain (7.12.96) - shows diffine cerebral oedema.
He was treated for 'Fat embolism'.
Im nailing was done (13.12.96) and fracture (right) Tibia-Fibula was treated conservatively.
Apparently, his general status was deteriorating and repeated chest X-ray suggestive of (right) pneumothorax with collapse of Lower lobes of (left) lung.
He was given intensive care and advise on continue aggressive management with antibiotics and cardiac support.
He developed bed sore, for which desloughing was done (2.1.97).
But no further improvement in his general status was noted.
He was transferred to ward on advise of poor prognosis for further management.
Further, his general status deteriorated though appropriate antibiotic was given corresponding to culture sensitivity results.
He became very ill on 5.1.97 and was found unresponding.
Active resuscitation was given, but no further improvement was noted.
Pronounced death on 5.1.97 at 6.55 am
Cause of death: 1. Septicaemic shock
2. Fat embolism

Move					Step
	Medical Report On				
1	Identity Card No.		Registration No		1A-1G
	Age		Sex		
	Date admission		Date Discharge		
Move 2	**History** 1. Patient presented with shortness of breath, chest pain and difficulty in breathing for two days prior to admission.				Step 1
Move 3	**On examination** 2. Vital signs were stable but air-entry was reduced over the (right) side with vocal resonance increased.				Step 2
	3. A diagnosis of (right) pneumothorax was made				Step 4
	chest-tube inserted but started on a course of antibiotics and physiotherapy.				Step 5
	4. Symptomatically patient's condition improved but lung did not expand fully. Air entry reduced slightly. 5. Finally on 12/8/96, chest tube removed and on examination, noted air-entry was equal, patient was well after that.				Step 2
	6. **Diagnosis:** (Right) Spontaneous pneumothorax.				Step 4
	7. **Investigation:** 1. FBC - Normal 2. BUSE - Normal 3. RBS - Normal 4. Chest X-rays.				Step 3
	8. **Treatment:** a) Chest-tube b) Antibiotics c) Physiotherapy				Step 5
Move 4	9. Patient was discharged on 14.8.97, he was a symptomatic, air entry equal and lung fluids fully expanded given appointment to see Mr Pasha in two weeks time in SOPD.				Step 1A & 1B

Move 1	Medical Report On				Step 1A-1G
	Identity Card No.		Registration No		
	Age		Sex		
	Date admission		Date Discharge		
Move 2	1. 72 years old Indian man who is a known diabetes mellitus for 10 years,				Step 1
	currently on Daonil 5 mg bd and Glucophage 1/1bd was diagnosed to have moderately differentiated adeno-carcinoma of stomach				Step 3
	through OGDS on 15/4/97.				Step 2
Move 3	2. Repeat OGDS done on 27/7/97 showed abnormal mucosa at cardio-oesophageal junction				Step 2
	and Total gastrectomy was done on 29.5.97 with esophago-jejunostomy and entero-enterostomy and splenectomy.				
	3. Post-operatively he was treated with I/V cefobid and flagyl with I/M Pethidine 50 mg 4(H)ly.				Step 5
	4. Subcutaneous insulin according to sliding scale was started to control his blood sugar.				
	5. He recovered well post operatively but developed bilateral basal pneumonia D3 post operation and				Step 1
	was treated with I/V Perfloxin.				Step 5
	6. Abdominal drain was off on D3 Post op. 7. His fever controlled and basal crepts reduced on D6 post op and he was started clear fluid then. 8. Ryle's tube was off and D7 post op after patient passed motion and nourishing fluid was started. 9. Insulin was off and changed to Daonil. 10. He was allowed soft diet D9 Post op				Step 2
Move 4	and patient was discharged well on D11 post op. 11. Diagnosis: Adenocarcinoma of stomach with gastrectomy done.				Step 1A

Move	Medical Report On				Step
	Identity Card No.		Registration No		
1	Age		Sex		1A-1G
	Date admission		Date Discharge		
Move 2	1. The above named patient was reviewed at the medical specialist clinic on 12th Feb 1997 as a case referred by the Government Polyclinic in Shah Alam.				Step 1
Move 3	2. On examination the following was noted: i) Gouty arthritis since 1985. ii) Renal calculi				Step 2
Move 2	3. He gives a history for frequent episodes of multiple large joint pains off and on especially involving the left knee and left ankle. 4. He also has pain and swelling of the other joint from time to time.				Step 1
	5. He has been on allopurinol 200 - 300 mg daily, yet he is subjected to repeated episodes of acute gout.				Step 2
Move 3	6. Local examination of the involved joints revealed, left knee and ankle, swollen, tender and reduced movement. 7. No gouty Tophus were noted 8. X-ray of the (left) knee revealed calcification of the (left) lateral ligament.				Step 2
	9. His Blood test done revealed: i) Uric Acid : 452 mmol/l ii) Blood Urea : 4.5 mmol/l III) Creatinine : 120 mmol/l 10. And his Urine FEME revealed: Albumin : Trace Pus cells : 2 - 3 Uric Acid Crystal				Step 3
	11. Final Diagnosis: Chronic Gout with Gouty Arthritis and Renal Calculi (Uric Acid Stone),				Step 4

Move 1	Medical Report On				Step 1A-1G
	Identity Card No.		Registration No		
	Age		Sex		
	Date admission		Date Discharge		
Move 2	1. Patient presented with recurrent left lumbar and loin pain since January 1991.				Step 1
Move 3	2. KUB was done showed left Staghorn Calculi				Step 3
	3. He was planned for left pyelolithotomy on the 15.8.91				Step 5
	4. Findings were Staghorn calculi left kidney.				Step 4
	5. Postoperatively patient was put on IV Netilmycin and patient was allowed orally when fully conscious.				Step 5
	6. He had one episode of low grade fever but settled on Day 3.				Step 2
	7. Abdominal drain was off on Day 4 post op. and nephrostomy tube drained clear urine. 8. Antegrade pyelogram was done on 27.8.91 and was normal and nephrostomy tube was clamped.				Step 5
	9. Patient was able to pass clear urine and				Step 2
	was discharged on 28.8.91 and TCA x 2/52 to SOPD.				Step 5
	Diagnosis: Left Staghorn Calculi with Left Pyelolithotomy done.				Step 4

Move 1	Medical Report On				Step 1A-1G
	Identity Card No.		Registration No		
	Age		Sex		
	Date admission		Date Discharge		
Move 2	1. Alleged involved in motor vehicle accident on 29.4.95 2. Sustained head injury with loss of consciousness. 3. He had fractured (right) parietal bone and had intra cerebral bleed which was				Step 1
	treated by surgical unit.				Step 3
Move 3	**Orthopaedically** 4. He had sustained compound fracture (left) 3rd metacarpal. 5. Treated conservatively with Plaster of paris cast and daily wound dressing. 6. Antibiotic was given.				Step 2
	7. He was discharged with advise on daily would dressing and given further follow-up.				Step 4
	On follow-up: 8. Noted the wound healed but the fracture of (left) 3rd metacapal angulated and deformed. 9. He was readmitted on 5.8.96 and osteotomy with K-wiring done on 7.8.96.				Step 5
	10. On follow-up the fracture has clinically united				Step 2
	K-wire was removed on 28.8.96. 11. He was advised on occupational therapy.				Step 5
Move 4	12. On discharge 30/10/96 - he had attained full Range of movement of (right) hand and finger with residual pain over the fracture site.				Step 1A

Move 1	Medical Report On				Step 1A-1G
	Identity Card No.		Registration No		
	Age		Sex		
	Date admission		Date Discharge		
Move 2	**History:** 1. Motorcyclist alleged involved in motor vehicle accident on 22.11.96 2. No loss of consciousness				Step 1
Move 3	**Injuries:** 3. Sustained injury to upper chest, (left hand and (left) foot.				Step 2
	X-ray: 4. Fracture manubriosternal joint. 5. Fracture promixal phalanx (left) middle finger. 6. Crack fracture proximal phalanx of (left) great toe.				Step 3
	Management: 7. Fracture manubriosternal joint and proximal phalanx (left) great toe treated conservative with Plaster of Paris Back slab applied on (left) foot. 8. K-wiring done for fracture proximal phalanx (left) middle finger. 9. Given regular follow-up. 10. K-wire removed on 26.12.96				Step 5
	11. Fracture united clinically.				Step 2
	12. He has restricted movement of (left) middle finger.				
	13. Advise on occupational therapy.				Step 5
	14. On last follow-up (24/2/97) he has residual restriction of movement PIP.				Step 2
Move 4	15. Advise on Light Duty with further follow-up.				Step 1B

Move 1	Medical Report On				Step 1A-1G
	Identity Card No.		Registration No		
	Age		Sex		
	Date admission		Date Discharge		
Move 2	**History:**				
	1. 50 years old Chinese woman known case of Diabetes				Step 1
	mellitus on oral hypoglycaemic agents.				Step 3
	2. Apparently well, had history of fever for which she was				Step 1
	given an injection over (right) gluteal region by a private practitioner.				Step 3
	3. Subsequently, she developed necrotising factitis extending from (right) gluteal region to (right) thigh associated with high grade fever.				Step 1
Move 3	4. She was admitted here on 20.2.97. 5. She was given aggressive management with antibiotics and Subcut Insulin. 6. Later proceeded with desloughing.				Step 5
	7. She also developed acute renal failure with wound slough with pus formation and was not responding to antibiotics.				Step 1
	8. Subsequently patient becomes very ill on 1.3.97.				Step 2
	9. She was put on cardiac monitor/support. Patient responded poorly to above management and on 2.3.97 10. She was gasping and did not responded to active CPR.				Step 5
Move 4	11. Pronounced death on 2.3.97 (6.50 am) 12. Cause of death due to: 1. Septicaemic shock secondary to necrotising fascitis and ARF.				Step 1C

Move 1	Medical Report On				Step 1A-1G
	Identity Card No.		Registration No		
	Age		Sex		
	Date admission		Date Discharge		
Move 2	1. This report is written according to the medical notes available. 2. Term, baby boy, birth weight 4.4 kgs, forceps delivery for prolonged 2nd stage on 29.8.96 @ 11.54 pm at a Private Maternity Hospital. 3. There was associated shoulder dystocia. Apgar Score - 2/5/8.				Step 1
Move 3	4. He was admitted to HTAR, Klang at 11¼ hours of life for cyanosis after 2 feedings.				Step 1
	5. On admission, he was in respiratory distress with cynosis and noted to have right brachial plexus injury.				Step 2
	6. Impression then was birth asphyxia and right brachial plexus injury.				Step 4
	7. He was ventilated for 3 days.				Step 5
	8. Subsequently he developed secondary pneumonia which required ventilation and intravenous antibiotics.				Step 2 Step 5
Move 4	9. On discharge, he was comfortable, active with good sucking reflex, however his right upper limb was still flaccid.				Step 1A